Chapter 2: Health Care Financing

This "Chapter 2" is original to Massachusetts Health Care Trends: 1990-1999.

The United States is the only industrialized country that does not universally insure its citizens for health care. Those without insurance can usually still obtain care, but it may not be preventive, timely or optimal. Massachusetts has deliberately set out to expand the number of residents with coverage and throughout the decade has succeeded at having a lower rate of uninsurance than the United States as a whole. But even for those who are not covered, Massachusetts has an established mechanism for paying for free care at both community health centers and hospitals which serves as a last resort safety net.

With one of the highest HMO penetration rates in the country, the financial health of our HMOs is of great concern. When HMOs uniformly began to report losses in the late 1990s there was widespread fear that our uniquely not-for-profit HMOs might not survive or might change to for-profit ownership. Considering the dismal financial status of the various types of care providers, the financial distress of HMOs rounded out a picture of an industry in trouble.

Insurance premiums are said to fluctuate in cycles and after being kept artificially low in the late 1990s, while HMOs sought market share, they are once again rising. Harvard Pilgrim Health Care sunk into receivership in early 2000, and many acknowledged that premiums had to rise. The health care system must be adequately funded—and people must be able to afford insurance.

Health Insurance Coverage

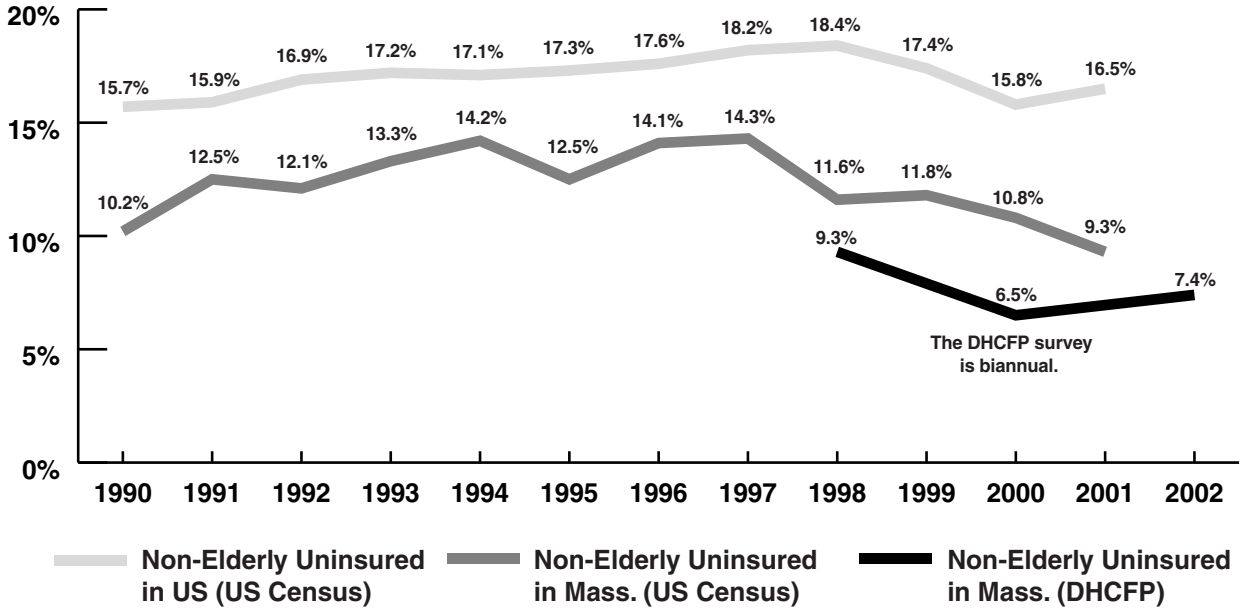
Employment-Based Health Insurance

(continued on page 20)

Medicaid Enrollment

Managed Care

Percent of Non-Elderly Uninsured Residents in the US and Massachusetts (1990-2002)



Sources: "Health Insurance Coverage Status and Type of Coverage by State, Persons Under 65: 1987-1998," Table HI-6, US Bureau of Census; Survey of Health Insurance Status of Massachusetts Residents, 1998 and 2000, Division of Health Care Finance and Policy; "Persons under 65 Years of Age without Health Care Coverage, by State: US, Selected Years 1987-2000," Health United States, 2002, US Department of Health and Human Services

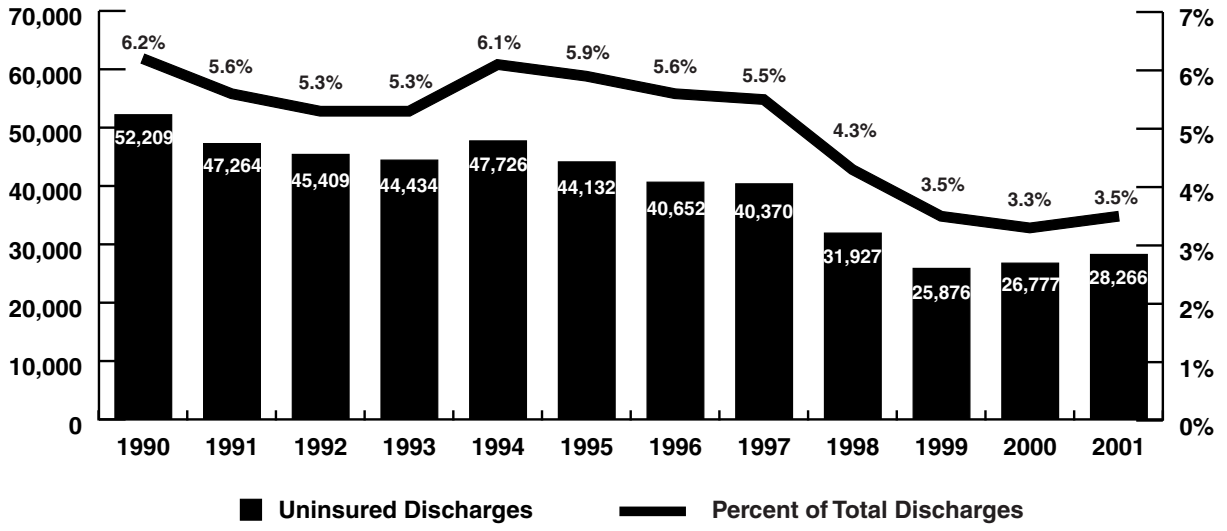
Notes: The DHCFP survey is biannual. The US Census methodology in 2000 changed slightly for both the count of US uninsured and its Massachusetts breakout of uninsured.

Figure 2.1

- According to the US Census, between 1990 and 2001, the proportion of Massachusetts residents who were uninsured was consistently well below the national rate.

- In 1998, the Division of Health Care Finance and Policy initiated a statewide survey of the health insurance status of state residents, and repeated it in 2000 and 2002. For a variety of technical reasons, DHCFP reports a lower and more accurate number of uninsured; it is widely agreed that the US census methodology overestimates the number of uninsured nationwide.

Number of Uninsured Acute Hospital Discharges and Percent of All Massachusetts Discharges (1990-2001)

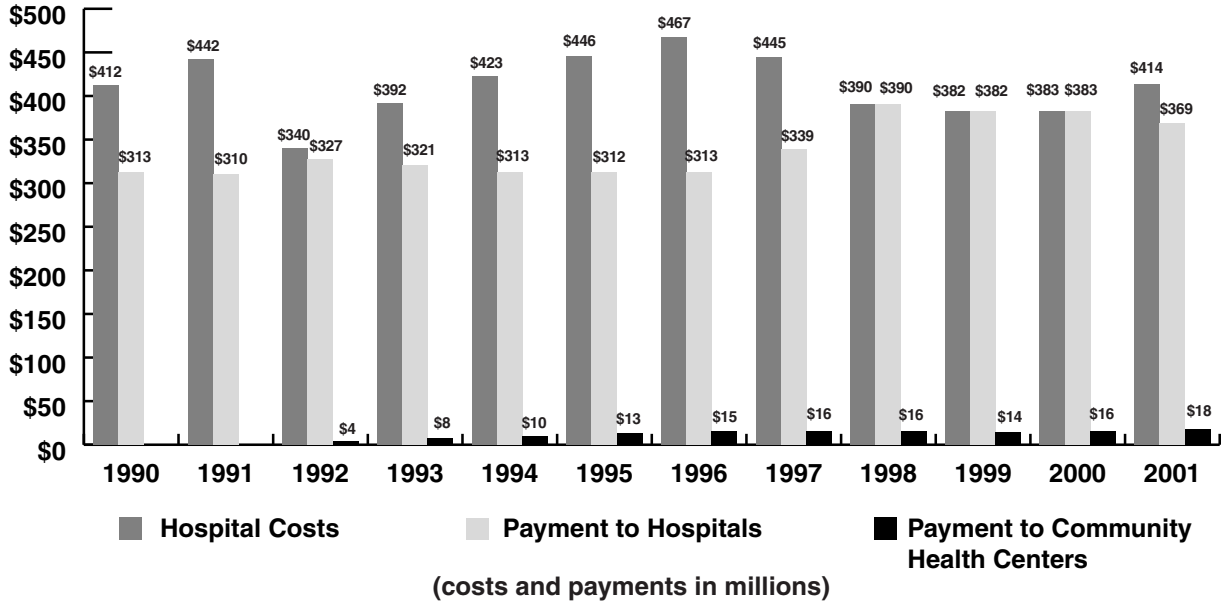


Source: Hospital discharge data, Massachusetts Division of Health Care Finance and Policy
Note: Uninsured includes self-pay and free care payer categories.

Figure 2.2

- During the 1990s, the number of uninsured acute hospital discharges decreased by almost 50%, but trended upward in 2001, as did the uninsured share of total discharges.

Allowable Cost and Actual Payment to Hospitals and CHCs for Uncompensated Care in Massachusetts (1990-2001)



Sources: *Uncompensated Care Pool PFY01 Annual Report*, August 2002 and "Community Health Center Payment Voucher Supplemental Form," Massachusetts Division of Health Care Finance and Policy

Note: These numbers have not been adjusted for inflation.

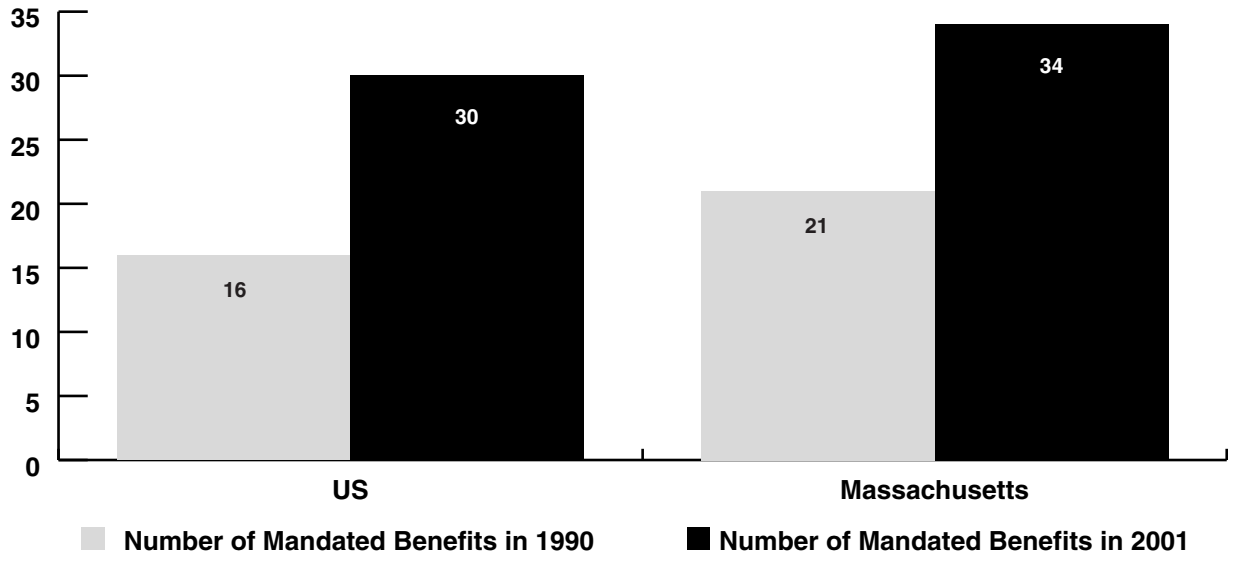
Figure 2.3

- The Massachusetts system for funding uncompensated care relies on several revenue sources: an assessment on acute hospitals' private sector charges, a surcharge on payments made to hospitals and ambulatory surgical centers by payers, and an annual appropriation from the Commonwealth's General Fund.

- As a result of policy changes in the financing and management of the Uncompensated Care Pool, as well as expansion in state supported health care coverage programs, the Pool was funded adequately from 1998 to 2000 to cover all charges to it. Prior to 1998, and again in 2001, uncompensated care charges were greater than the dollars available to fund such care, resulting in a shortfall.

- Since 1992, the Uncompensated Care Pool has paid community health centers (CHCs) for the uncompensated care they provide. Unlike hospitals, the Pool pays CHCs based on a standard fee schedule. Also unlike hospitals, CHC payments from the Pool are not reduced when there is a shortfall in Pool funds, therefore, there is no difference between allowable costs and payments for CHCs as there is for hospitals.

Number of Mandated Health Insurance Benefits in the US and Massachusetts (1990 and 2001)



Source: *State Legislative Health Care Insurance Issues: 2001 Survey of Plans*, Blue Cross Blue Shield Association

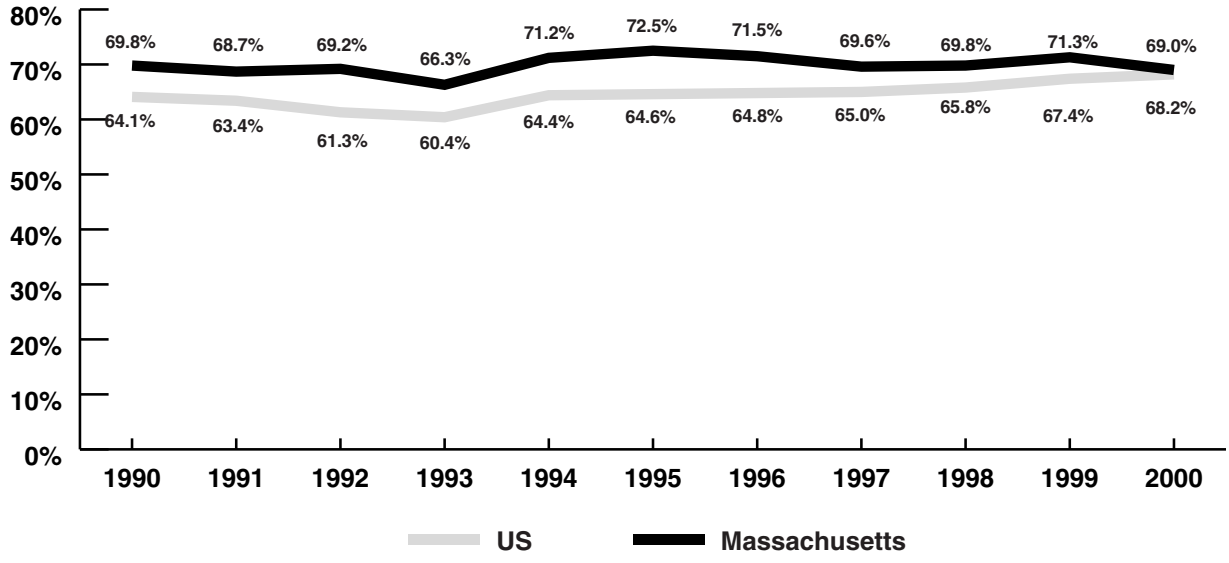
Figure 2.4

- All 50 states have laws requiring employers that offer group health plans to include minimum specific benefits, although, according to federal law, these mandates do not apply to self-funded ERISA plans, primarily offered by large companies.

- The number of mandates alone, however, is not an indicator of premium costs. Some benefits add more cost to premiums than others.

- Mandated health benefits offer the advantage of ensuring that individuals with insurance have access to coverage for specific benefits. A disadvantage is that benefit mandates may increase the cost of insurance coverage, thereby possibly raising the number of uninsured.

Percent of Non-Elderly with Employer-Based Health Insurance in the US and Massachusetts (1990-2000)

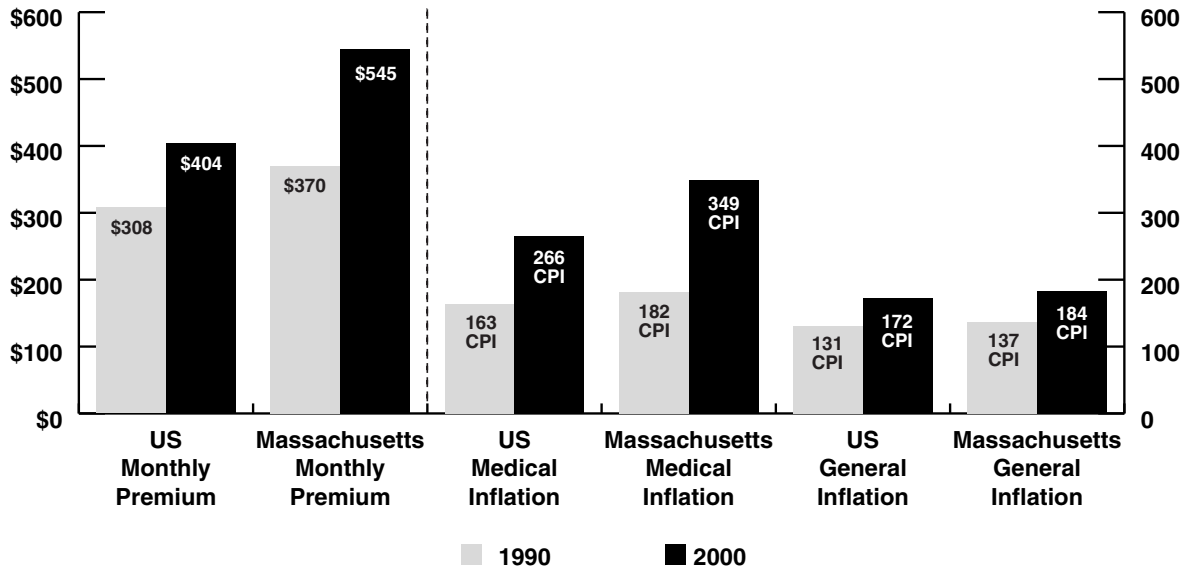


Source: "Health Insurance Coverage Status and Type of Coverage by State, Persons Under 65: 1987-2000," Table HI-6, US Bureau of Census

Figure 2.5

- Throughout the decade, Massachusetts had a larger proportion of its population covered by employer-based health insurance than the rest of the nation.
- The higher rate of employer-sponsored health insurance in Massachusetts is associated with its larger-than-average-sized employers, higher-than-average per capita incomes, higher-than-average union penetration, and a lower-than-average number of service jobs in the state economy.

HMO Premiums, Medical Inflation and General Inflation in the US and Massachusetts (1990 and 2000)



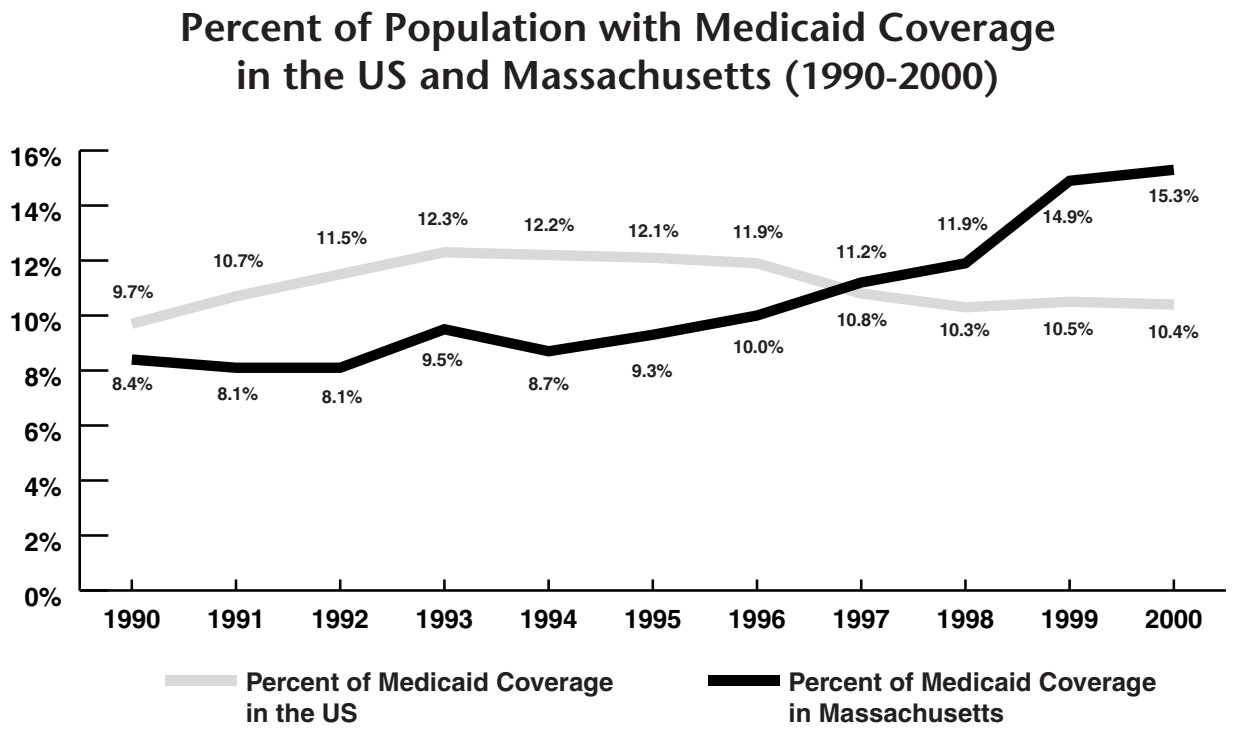
Sources: *Health, United States, 2001,* US Department of Health and Human Services; *HMO Rate Analysis: 1998 Spending, Unit Cost and Utilization* and *Premium Trends for Six HMOs in Massachusetts: 1990-1994,* Massachusetts Division of Health Care Finance and Policy; *Statistical Abstracts of the US* (Boston, Massachusetts, only), US Bureau of Census

Note: These numbers have not been adjusted for inflation.

Figure 2.6

- The average (of family and individual rate) monthly Massachusetts health insurance premium increased significantly more (47%) than that of average premiums throughout the country (39%), but significantly less than the rate of medical inflation in Massachusetts (92%).

- Throughout the decade, general inflation in Massachusetts (34%) was similar to that of the US as a whole (32%); medical inflation in Massachusetts was significantly higher than medical inflation in the US (92% versus 63%).

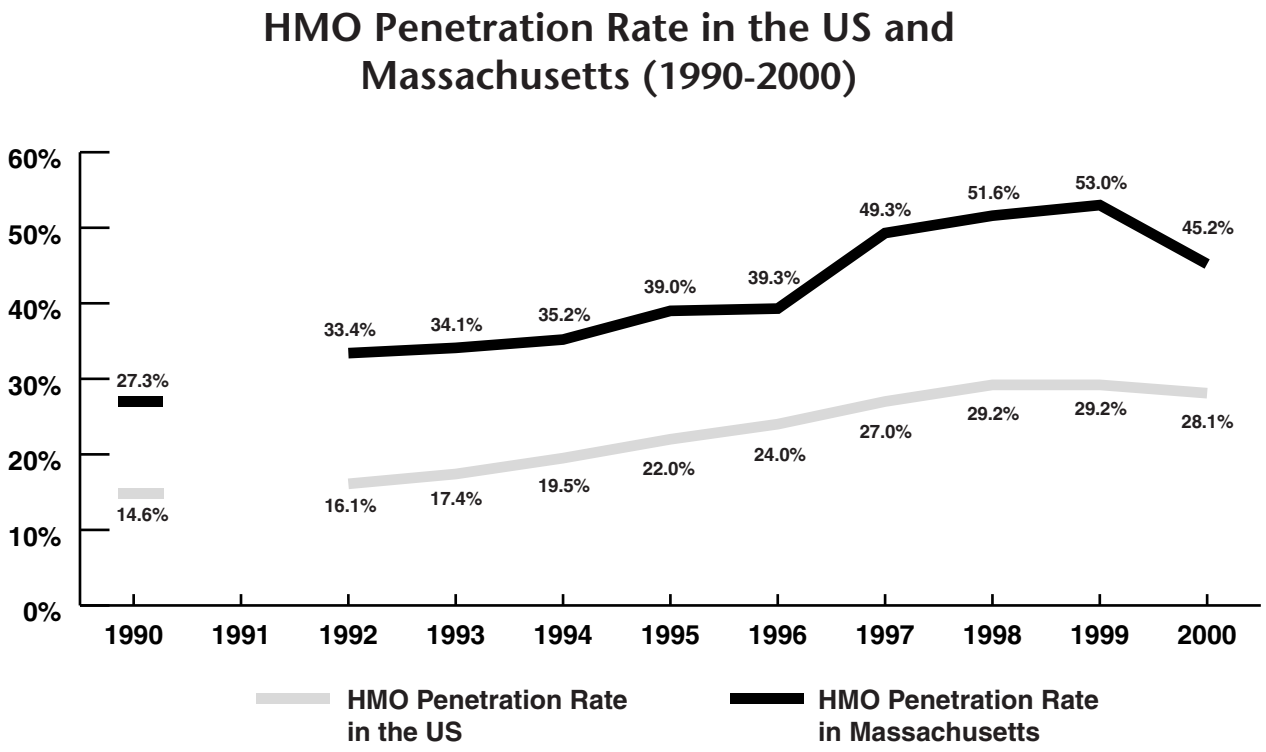


Source: "Health Insurance Coverage Status and Type of Coverage by State, Persons Under 65: 1987-2000," Table HI-6, US Bureau of Census

Figure 2.7

- Between 1990 and 2000, the number of Medicaid enrollees in the state rose considerably due to deliberate expansion and successful outreach by MassHealth. Policy changes in 1997 that promoted increased Medicaid enrollment in Massachusetts included the approval of a federal 1115 waiver demonstration project and the implementation of Children's Health Insurance Program (CHIP), which became a model for the rest of the country.

- Between 1990 and 2000, national Medicaid enrollment increased slightly, having peaked at 12.3% of the population in 1993. National welfare reform, enacted in 1996, lowered Medicaid enrollment, although many former welfare recipients are still legally entitled to Medicaid benefits.

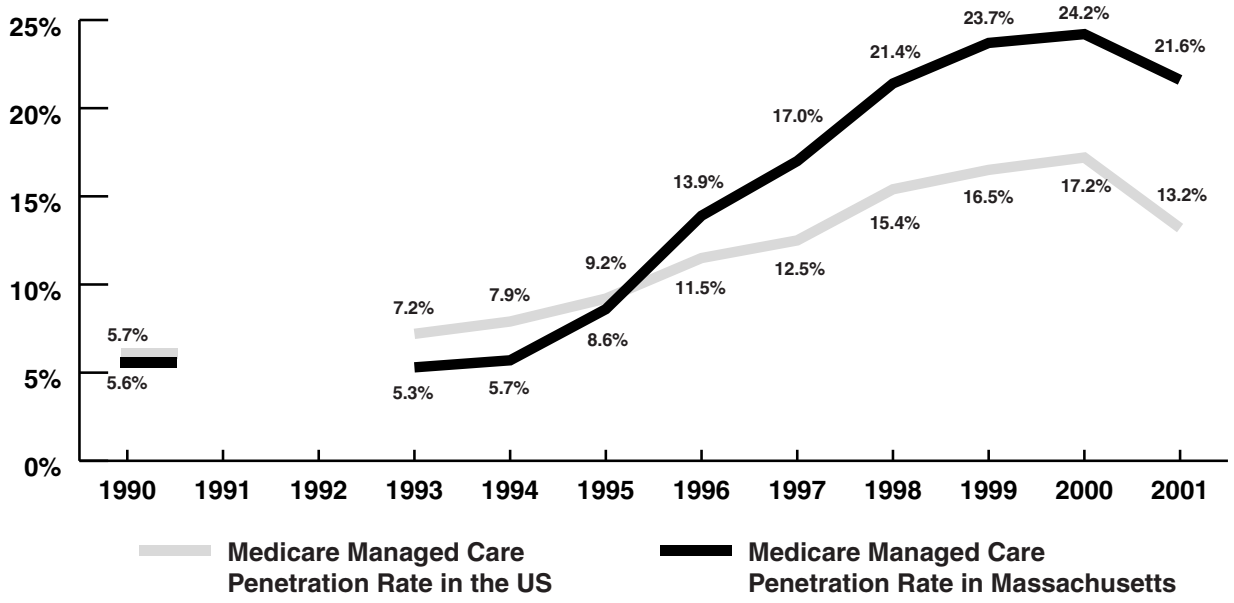


Source: *Reforming the Health Care System: State Profiles* (1990-2001), American Association of Retired People (AARP)
Notes: Complete data were unavailable for 1991. Includes Medicaid, Medicare, and private commercial members.

Figure 2.8

- In 2000, Massachusetts had the second highest HMO penetration rate in the country after California (not shown). Throughout the decade, the Massachusetts HMO penetration rate substantially exceeded the national rate.

Managed Care Penetration Rate of the Medicare Population in the US and Massachusetts (1990-2001)



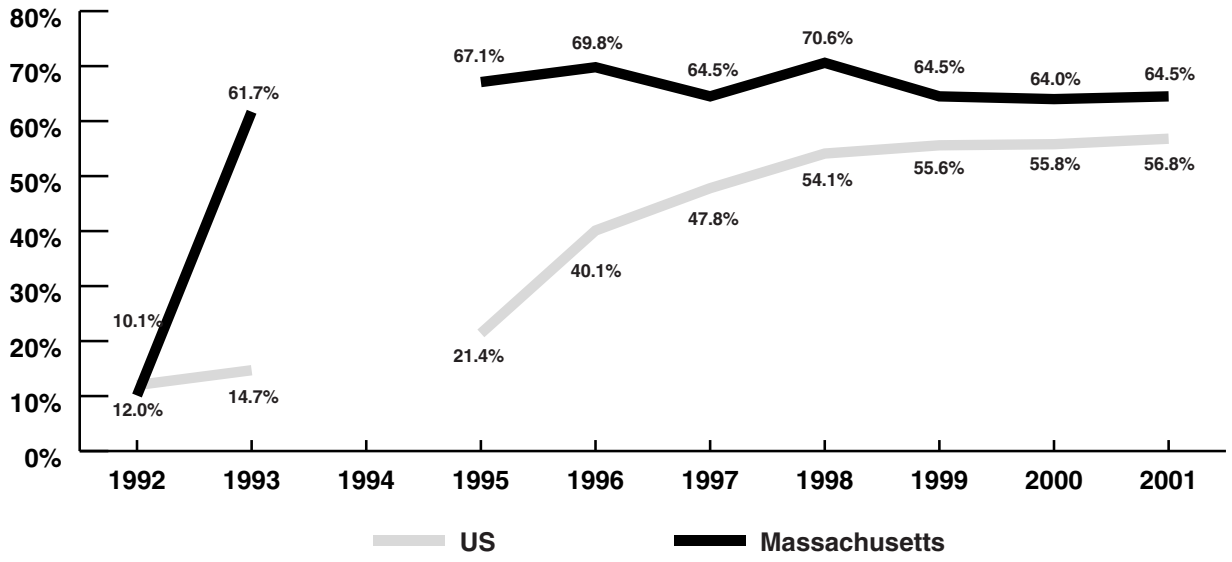
Sources: *Reforming the Health Care System: State Profiles* (1990-2001), American Association of Retired People (AARP); *Health, United States, 1999,* US Department of Health and Human Services; www.cms.hhs.gov/healthplans/statistics/mpscr, September 2001/SC-0902

Note: Complete data were unavailable for 1991 and 1992.

Figure 2.9

- Following the pattern set by the commercial population, the managed care penetration rate for Medicare enrollees is higher in Massachusetts than the national average and has been consistently higher since 1996. However, due to dissatisfaction with the capitation rates paid to them by the Center of Medicare and Medicaid Services, HMOs in Massachusetts and elsewhere continue to withdraw from participation in the program in various counties.

Managed Care Penetration Rate of the Medicaid Population in the US and Massachusetts (1992-2001)

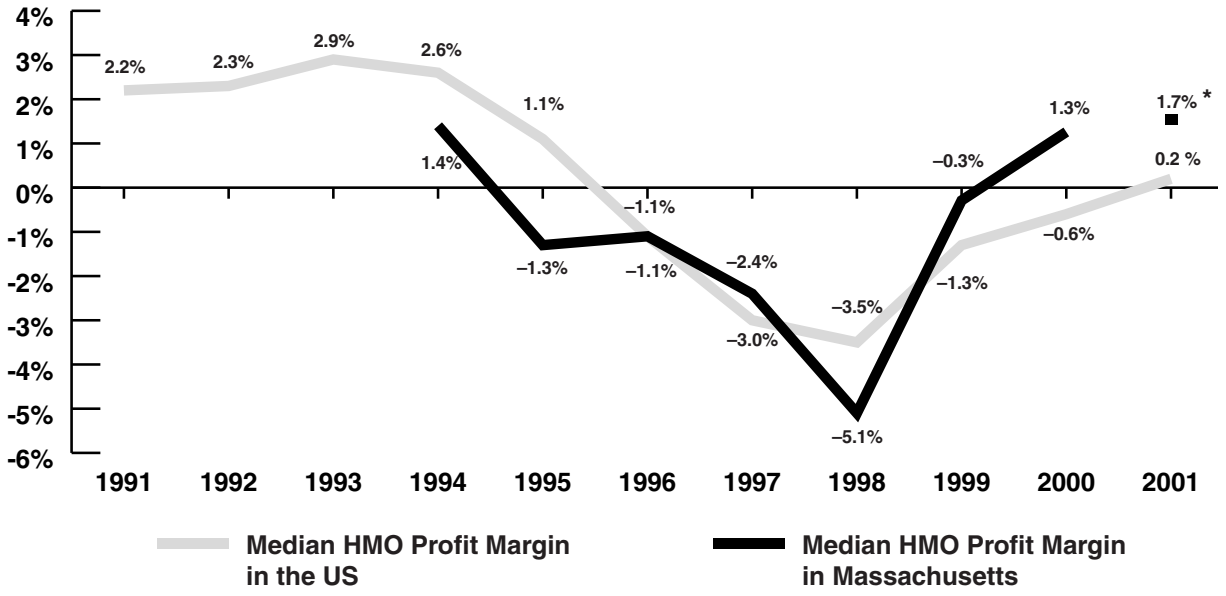


Source: *Reforming the Health Care System: State Profiles* (annual reports 1993-2001), American Association of Retired People (AARP)
Notes: Complete data were unavailable for 1994; www.cms.hhs.gov/medicaid/managedcare/mcsten99.pdf. The Massachusetts penetration rate includes Medicaid beneficiaries enrolled in its managed Primary Care Clinician Program.

Figure 2.10

- As with the commercial and Medicare populations, the managed care penetration rate for Medicaid enrollees is higher in Massachusetts than the national average. However, almost all such enrollees are in Medicaid's own Primary Care Clinician Program.

Median HMO Profit Margin in the US and Massachusetts (1991-2001)



Sources: Massachusetts Association of Managed Care Organizations; "InterStudy HMO Financial Performance Report and Outlook," InterStudy Publications, November 2002, www.interstudypublications.com/samples/financial/fin%20report%20example.pdf; HMO Special Report, November 2002, Massachusetts Hospital Association

Notes: Complete data were unavailable for 1991, 1992, and 1993. Some HMOs do business outside Massachusetts and their filings indicate profit or loss of the company as a whole, rather than for the portion of income and expenses attributable to Massachusetts operations.

Figure 2.11

- In the early 1990s, the market for HMO enrollment became increasingly competitive and HMO plans merged (see Appendix II, page 89), increasing pressure for expensive compatible data and financial systems. In addition, purchaser pressure to rein in premium costs contributed to declining plan profit margins. Some HMOs undertook costly and fruitless out-of-state expansions, which were largely abandoned (at great loss) by the end of the decade.

- Up until 1999, the HMO's grim financial standing mirrored that of hospitals (see Figure 3.22, page 57), nursing homes (see Figure 3.23, page 58), and community health centers (see Figure 3.24, page 59). HMOs in Massachusetts started to recover in 1999, but didn't generate a profit until 2000; operating margins for institutional providers, however, are still below zero.

** 2001 data for Median HMO Profit Margin in Massachusetts came from the Massachusetts Hospital Association, a different source than in prior years.*